Application Checklist for Foreign Graduates

Required Professional Experience

Speech-Language Pathologist

1. **Application**

2. **License Fees**
   - Check or Money Order to Board for $60

3. **Coursework Evaluation Report**

~~~Once your coursework is approved by the Board, you may continue on with the application process and submit items 4-10.~~~

4. **Temporary License Application**

5. **Acknowledgement Statement**

6. **RPE Supervisor Responsibility Statement**

7. **Copy of Social Security Card**

8. **Fingerprints**
   - If a California resident, must do Livescan; send copy of your form to the Board. Fees paid directly to Livescan Operator.
   - If out-of-state, send four cards and a check or money order to Board for $49 to cover DOJ and FBI.

9. **National Exam**
   - Must have minimum passing score of 600.
   - Must be within five years.
   - Must be sent from Praxis to our Board

10. **RPE Verification Form**
    - Submit within 10 days upon RPE completion.
    - Submit a verification form for each public school year.
    - Provide a calendar for each school year including summer sessions.
    - Letter form the school district defining the dates and hours of the summer session.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
2005 EVERGREEN STREET, SUITE 2100, SACRAMENTO, CA 95815
PHONE (916) 263-2666 FAX (916) 263-2668
WWW.SPEECHANDHEARING.CA.GOV

APPLICATION FOR LICENSURE
(FOREIGN GRADUATES)
$60.00

OFFICE USE ONLY	
RECEIPT #:	
ATS #:	
AMOUNT PAID:	
DATE CASHIERED:	

INSTRUCTIONS: YOU MUST COMPLETE THIS ENTIRE APPLICATION. ANY CORRECTIONS TO THIS FORM MUST BE STRICKEN AND INITIALED. **DO NOT USE WHITE OUT OR CORRECTION TAPE ON THIS APPLICATION**. IF ANY SECTIONS ARE NOT COMPLETE, THIS APPLICATION WILL BE RETURNED. YOU MUST INCLUDE A CHECK OR MONEY ORDER IN THE AMOUNT OF $60.00 ALONG WITH THIS APPLICATION.

SPEECH-LANGUAGE PATHOLOGY ____ **AUDIOLOGY** ____ **DISPENSING AUDIOLOGIST** ____

(PLEASE TYPE OR PRINT NEATLY)

1. FULL NAME: LAST FIRST MIDDLE

2. OTHER NAMES YOU HAVE USED (INCLUDING MAIDEN):

3. *ADDRESS: STREET

CITY, STATE, ZIP CODE

4. RESIDENCE TELEPHONE: BUSINESS TELEPHONE:

5. SOCIAL SECURITY NUMBER: DATE OF BIRTH: (MM/DD/YYYY)

EMAIL ADDRESS:

6. EDUCATION:

MASTER'S DEGREE ____ MASTER'S DEGREE EQUIVLENCY ____ AU.D DEGREE OR AU.D. STUDENT ____

7. GRADUATE AND UNDERGRADUATE PROGRAMS. YOU MUST PROVIDE GRADUATE AND UNDERGRADUATE TRANSCRIPTS.

INSTITUTION NAME	LOCATION/COUNTRY	MAJOR FIELD OF STUDY	DEGREE RECEIVED AND DATE

8. HAVE YOU TAKEN THE EDUCATIONAL TESTING SERVICE/NATIONAL TEACHER EXAMINATION (NTE) (THE PRAXIS SERIES) IN SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY WITHIN THE PREVIOUS 5 YEARS?

YES _____ NO _____

NOTE: YOU MUST HAVE THE EDUCATIONAL TESTING SERVICE (PRAXIS SERIES) SEND STANDARD SCORE EXAMINATION RESULTS DIRECTLY TO OUR OFFICE.

9. HAVE YOU COMPLETED ANY PORTION OF YOUR CFY/RPE IN ANOTHER STATE?

YES _____ NO _____ IF YES, LIST THE STATE(S):_____

IF YOU WISH TO USE THIS EXPERIENCE YOU WILL BE REQUIRED TO SUBMIT A REQUIRED PROFESSIONAL EXPERIENCE VERIFICATION FORM.

10. HAVE YOU EVER BEEN LICENSED TO PRACTICE SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY IN ANY STATE OR COUNTRY?

YES _____ NO _____ IF YES, WHAT STATE(S) OR COUNTRY _____

11. DO YOU HAVE ANY PENDING OR HAVE YOU EVER HAD ANY DISCIPLINARY ACTION TAKEN OR CHARGES FILED AGAINST A SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS LICENSE? INCLUDE ANY DISCIPLINARY ACTIONS TAKEN BY ANY STATE OR OTHER U.S. FEDERAL GOVERNMENT ENTITY.

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

DISCIPLINARY ACTION INCLUDES, BUT IS NOT LIMITED TO, SUSPENSION, REVOCATION, PROBATION, CONFIDENTIAL DISCIPLINE, CONSENT ORDER, LETTER OF REPRIMAND OR WARNING, OR ANY OTHER RESTRICTIONS OF ACTION TAKEN AGAINST A SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY LICENSE.

12. ARE THERE ANY PENDING INVESTIGATIONS BY ANY STATE OR FEDERAL AGENCIES AGAINST YOU?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

13. HAVE YOU EVER BEEN THE SUBJECT OF ANY DISCIPLINARY ACTION REGARDING ANY SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS LICENSE, WHICH YOU NOW HOLD OR HAVE PREVIOUSLY HELD?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

14. HAVE YOU EVER BEEN DENIED A LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS, IN ANY STATE OR COUNTRY?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

15. HAVE YOU EVER VOLUNTARILY SURRENDERED A LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY HEARING AID DISPENSING, OR OTHER HEALING ARTS IN ANOTHER STATE OR COUNTRY?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

16. HAVE YOU EVER BEEN CONVICTED OF, OR PLED NOLO CONTENDERE TO ANY OFFENSE, MISDEMEANOR OR FELONY OF ANY STATE, THE UNITED STATES OR A FOREIGN COUNTRY? (EXCEPT VIOLATIONS OF TRAFFIC LAWS RESULTING IN FINES OF $300 OR LESS)

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND/OR DISMISSED UNDER PENAL CODE SECTION 1203.4 OR UNDER ANY OTHER PROVISION OF THE LAW.

17. AUDIOLOGY APPLICANTS ONLY, DO YOU WISH TO DISPENSE HEARING AIDS?

YES _____ NO _____ IF YES, COMPLETE THE HEARING AID DISPENSER WRITTEN LICENSE EXAMINATION APPLICATION

YOU MUST REPORT TO THE BOARD THE RESULT OF ANY ACTIONS WHICH HAVE BEEN FILED OR WERE PENDING AGAINST ANY SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY LICENSE YOU HOLD AT THE FILING OF THIS APPLICATION. FAILURE TO REPORT THIS INFORMATION MAY RESULT IN THE DENIAL OF YOUR APPLICATION OR SUBJECT YOUR LICENSE TO DISCIPLINE PURSUANT TO SECTION 480 (C) OF THE BUSINESS AND PROFESSIONS CODE.

ATTACH 2" X 2" OR 3" X 3"
PASSPORT QUALITY
PHOTOGRAPH HERE. YOU MUST PRINT YOUR FULL NAME ON THE BACK OF THE PHOTOGRAPH. THE PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE 60 DAYS OF THE FILING DATE OF THIS APPLICATION.

PHOTOS PRINTED ON WHITE PAPER ARE **NOT** ACCEPTABLE.

I HEREBY CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL STATEMENTS MADE HEREIN ARE TRUE IN EVERY RESPECT, AND THAT MISSTATEMENTS OR OMISSIONS OF MATERIAL FACTS MAY BE CAUSE FOR DENIAL OF THIS APPLICATION, OR FOR SUSPENSION OR REVOCATION OF A LICENSE.

DATE: _____ SIGNATURE: _____
(SIGNATURE MUST BE IN BLUE INK)

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APPLICATION FOR TEMPORARY REQUIRED PROFESSIONAL EXPERIENCE LICENSE (FOREIGN APPLICANTS)

INSTRUCTIONS: YOU MUST COMPLETE ALL SECTIONS OF THIS APPLICATION. ANY CORRECTIONS MUST BE STRICKEN AND INITIALED. **DO NOT USE LIQUID PAPER OR CORRECTION TAPE ON THIS FORM.** YOU MAY NOT PROVIDE PROFESSIONAL SERVICES UNTIL YOU HAVE RECEIVED APPROVAL FROM THIS OFFICE.

NOTICE: EFFECTIVE JULY 1, 2012, THE STATE BOARD OF EQUALIZATION, AND THE FRANCHISE TAX BOARD MAY SHARE TAXPAYER INFORMATION WITH THE BOARD. YOU ARE OBLIGATED TO PAY YOUR STATE TAX OBLIGATION AND YOUR LICENSE MAY BE SUSPENDED IF THE STATE TAX OBLIGATION IS NOT PAID.

PART A, TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT LEGIBLY.

AME: **LAST** FIRST MIDDLE

2. OTHER NAMES YOU HAVE USED (INCLUDING MAIDEN):

3. *ADDRESS: STREET

CITY, STATE, ZIP CODE

4. RESIDENCE TELEPHONE: BUSINESS TELEPHONE:

5. SOCIAL SECURITY NUMBER: DATE OF BIRTH: (mm/dd/yy)

6. LICENSE CATEGORY IN WHICH RPE IS REQUESTED:
SPEECH-LANGUAGE PATHOLOGY ____ AUDIOLOGY ____

7. EMAIL ADDRESS:

8. NUMBER OF RPE EMPLOYMENT HOURS PER WEEK:
____ 30-40 (FULL-TIME) ____ 15-29 (PART-TIME)

9. PROPOSED START DATE:
AS SOON AS APPROVED ____ FUTURE DATE: _____
YOU MAY **NOT** BEGIN WORKING ON THIS DATE UNLESS YOU HAVE RECEIVED APPROVAL FROM THIS OFFICE.

*YOUR ADDRESS IS PUBLIC INFORMATION AND WILL BE PLACED ON THE INTERNET.

PART B, TO BE COMPLETED BY THE RPE SUPERVISOR. REFER TO TITLE 16, CALIFORNIA CODE OF REGULATIONS, SECTION 1399.153.3 FOR SUPERVISOR'S RESPONSIBILITIES.

10. NAME OF SUPERVISOR: **LAST** FIRST MIDDLE

ADDRESS: STREET

CITY, STATE, ZIP CODE

11. BUSINESS TELEPHONE: LICENSE NUMBER

APPLICANTS FULL NAME _____ SOCIAL SECURITY NUMBER _____

12. LIST OF PLACE(S) WHERE FUNCTIONS WILL BE PERFORMED:

FACILITY OR SCHOOL NAME (DO NOT USE ABBREVIATIONS) ADDRESS CITY, STATE, ZIP CODE

FACILITY OR SCHOOL NAME (DO NOT USE ABBREVIATIONS) ADDRESS CITY, STATE, ZIP CODE

FACILITY OR SCHOOL NAME (DO NOT USE ABBREVIATIONS) ADDRESS CITY, STATE, ZIP CODE

13. IS THE SETTING(S) LISTED IN QUESTION #12 A PUBLIC SCHOOL?
YES _____ NO _____

IF YES, IS THE RPE:

_____ A SALARIED EMPLOYEE OF THE SCHOOL PUBLIC OR COUNTY OFFICE OF EDUCATION.

_____ PAID BY A CONTRACT AGENCY AND PLACED IN THE PUBLIC SCHOOL.

14. SUPERVISION:

_____ THE RPE WILL BE WORKING FULL-TIME AND I AGREE TO PROVIDE EIGHT HOURS A MONTH DIRECT SUPERVISION. FOUR OF THE EIGHT HOURS WILL BE IN SCREENING, THERAPY, AND EVALUATION.

_____ THE RPE WILL BE WORKING PART-TIME AND I AGREE TO PROVIDE FOUR HOURS A MONTH DIRECT SUPERVISION. TWO OF THE FOUR HOURS WILL BE IN SCREENING, THERAPY, AND EVALUATION.

15. THE FOLLOWING APPLICANTS HAVE BEEN APPROVED OR ARE PENDING APPROVAL TO OBTAIN THEIR RPE EXPERIENCE UNDER MY SUPERVISION:

_____ AUDIOLOGY _____ SPEECH-LANGUAGE PATHOLOGY _____
RPE'S FULL NAME

_____ AUDIOLOGY _____ SPEECH-LANGUAGE PATHOLOGY _____
RPE'S FULL NAME

I, THE RPE APPLICANT, HAVE DISCUSSED THE PLAN FOR SUPERVISION WITH THIS SUPERVISOR (NAMED ON REVERSE SIDE) AND AGREE TO ITS IMPLEMENTATION. I FURTHER CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL STATEMENTS MADE ARE TRUE AND CORRECT. ANY MISREPRESENTATION MAY BE CAUSE FOR DENIAL OF MY TEMPORARY LICENSE.

APPLICANT'S SIGNATURE _____ DATE SIGNED _____
(**SIGNATURE MUST BE IN BLUE INK)**

I, THE RPE SUPERVISOR, HAVE DISCUSSED THE PLAN FOR SUPERVISION WITH THE RPE APPLICANT AND HEREBY ACCEPT PROFESSIONAL AND ETHICAL RESPONSIBILITY FOR HIS OR HER PERFORMANCE. I FURTHER CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL STATEMENTS MADE ARE TRUE AND CORRECT.

I HAVE COMPLETED THE INITIAL 6 HOURS OF CONTINUING PROFESSIONAL DEVELOPMENT IN SUPERVISION TRAINING AND WILL COMPLETE 4 HOURS EVERY OTHER RENEWAL CYCLE HEREAFTER.

SUPERVISOR'S SIGNATURE _____ DATE SIGNED _____
(**SIGNATURE MUST BE IN BLUE INK)**

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RPE TEMPORARY LICENSE ACKNOWLEDGMENT STATEMENT

RPE temporary license applicants must read and sign this statement. The signed page must be returned with the Temporary Required Professional Experience License application.

As an RPE temporary license holder, I am responsible for ensuring the following standards are complied with during my RPE experience.

1) I have read and understand the excerpts of the laws and regulations, included with my application, pertaining to the responsibilities of an RPE temporary license holder.

2) My supervisor shall maintain a current license issued by the Speech-Language Pathology and Audiology Board during the entire time he or she is supervising my experience. **If my supervisor's license expires during the course of my experience, I will report the situation to the Board for further action.**

   The supervisor's license may be verified at any time at the Board's website at www.slpab.ca.gov.

3) I understand that I must complete 36 weeks of full-time experience (defined as 30-40 hours per week) with 8 hours per month direct supervision or 72 weeks of part-time experience (defined as 15-29 hours per week) with 4 hours per month of direct supervision to be eligible for a permanent license.

4) If there is an extended break in experience due to a vacation or illness, it is my responsibility to notify the Board of the exact dates of the breaks. I will not receive credit for the time identified.

5) Should I decide to alter my RPE plan at any time, it will be my responsibility to ensure that all of the standards set forth in this document and the laws and regulations are complied with for each new RPE plan.

6) As defined in California Code of Regulations Section 1399.153.4., I understand that should my supervisor supervise more than 3 RPE temporary license holders at any time during my experience, I will not receive credit for that time.

7) At the time of termination of supervision, I will ensure that my supervisor completes the Required Professional Experience (Verification) form. I understand that it is my responsibility to return the Verification form within 10 days of completion.

8) The following occurrences will result in a loss of credit in experience:
   - Supervisor's license expired while I was practicing under his/her supervision.
   - Supervisor is supervising more than 3 RPE temporary license holders at any time during my RPE plan.
   - Insufficient hours worked to satisfy part-time requirements (15-29 hours per week) or full-time requirement (30-40 hours per week).
   - Inadequate hours of supervision for part-time requirement (4 hours per month) or full-time requirement (8 hours per month)
   - Unreported break in experience that resulted in an insufficient number of weeks worked.

Please keep this page for your records.

I hereby acknowledge that I have received and read, in its entirety, the RPE Temporary License Acknowledgement Statement. I understand what is expected of me and agree to follow these guidelines. Failure to do so will result in a denial of credit for the professional experience.

_____	_____
Signature of RPE Applicant (in blue ink)	Social Security Number
_____	_____
Print Full Name of Applicant	Date
_____	
Mailing Address	
_____	
City, State, Zip Code	

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REQUIRED PROFESSIONAL EXPERIENCE SUPERVISOR RESPONSIBILITY STATEMENT

All qualified speech-language pathologists or audiologists who assume responsibility for providing supervision to a required professional experience (RPE) temporary license holder must complete and sign under penalty of perjury, the following statement. The signature page must be included with the Required Professional Experience Temporary License Application.

1) I possess the following qualifications to supervise a speech-language pathology or audiology applicant:

   A California license issued by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, or

   If employed by the public school, a valid, current, and professional clear credential authorizing service in language speech, and hearing issued by the Commission on Teacher Credential.

2) I agree to ensure that either my California license or my official credential is renewed in a timely manner. Failure to do so could result in a loss of credit for experience obtained by the RPE.

3) I agree to provide 8 hours direct supervision per month for each full-time RPE and 4 hours direct supervision per month for each part-time RPE. (Full-time is defined as 30-40 hours per week. Part-time is defined as 15-29 hours per week).

4) I will not supervisor more than 3 RPE's at any one time pursuant to Section 1399.153.4 of the California Code of Regulations.

5) I will immediately notify the RPE of any disciplinary action, including revocation, suspension, even if stayed, probation terms, inactive license, or lapse in licensure that affects my ability or right to supervise.

6) I know and understand the laws and regulations pertaining to the supervision of the RPE's and the experience required.

7) I will ensure that the extent, kind, and quality of the clinical work performed is consistent with the training and experience of the RPE and shall be accountable for the assigned tasks performed by the RPE.

8) At the time of termination of supervision, I will complete the Required Professional Experience Verification form. I will submit the original signed form to the board within 10 calendar days of termination of supervision.

9) I have completed the initial 6 hours of continuing professional development in supervision training and will complete 4 hours every other renewal cycle hereafter.

Please keep this page for your records

REQUIRED PROFESSIONAL EXPERIENCE
SUPERVISOR RESPONSIBILITY STATEMENT
SIGNATURE PAGE
(NEW APPLICANTS ONLY)

I

_____ _____

Applicants Full Name | Applicants Social Security Number

_____

Address

_____

City | State | Zip Code

I declare under penalty of perjury under the laws of the State of California that I have read and understand the foregoing. I further certify that all information submitted on this form is true and correct.

_____ _____

Supervisor's Signature (in blue ink) | Date

_____ _____

Print Name | California License Number or Credential # (If not licensed, please attach a copy of the front AND back of your credential.)

_____

Address

_____

City | State | Zip Code

Please return this signed page along with the Required Professional Experience Temporary License Application, page 2 of the RPE Acknowledgement Statement, copy of the Request for Livescan Service Request form and $60.00 license fee.

(Rev AUG-11)

STATE OF CALIFORNIA
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REQUIRED PROFESSIONAL EXPERIENCE VERIFICATION FORM

INSTRUCTIONS AND IMPORTANT INFORMATION: This form must be completed and submitted within 10 business days of termination of supervision, change in time base or at the end of your experience. Full-time and part-time experience can not be combined on the same form. If you are working in a public school you will be required to submit a separate verification form for each school year. You must also provide a calendar for each school year. If you work during the summer you will be required to submit a separate verification form for the summer session. You will also be required to provide a letter from the school district that defines the dates and hours of the summer school session. Any corrections to this form must be stricken and initialed by the supervisor. Do **NOT** use white out or correction tape on this form. Do **not** fax this form to the Board.

THIS SECTION MUST BE COMPLETED BY THE APPLICANT. PLEASE TYPE OR PRINT LEGIBLY.

1. APPLICANT'S NAME: LAST FIRST MIDDLE

2. APPLICANT'S ADDRESS OF RECORD: WOULD YOU LIKE YOUR ADDRESS CHANGED? _____ YES _____ NO

_____
SIGNATURE AUTHORIZING ADDRESS CHANGE

CITY, STATE, ZIP CODE: PHONE NUMBER: ( )

3. SOCIAL SECURITY NUMBER: - - RPE NUMBER: DATE OF BIRTH: (MM/DD/YY) / /

EMAIL ADDRESS: (OPTIONAL)

THIS SECTION MUST BE COMPLETED BY THE SUPERVISOR. PLEASE TYPE OR PRINT LEGIBLY.

4. SUPERVISOR'S NAME: LAST FIRST LICENSE NUMBER:

5. SUPERVISOR'S ADDRESS:

CITY, STATE, ZIP CODE:

6. NAME AND ADDRESS WHERE EXPERIENCE WAS ACTUALLY OBTAINED: (DO NOT PROVIDE AGENCY INFORMATION)

7. STREET ADDRESS:

8. CITY, STATE, ZIP CODE: PHONE NUMBER: ( )

9. NUMBER OF HOURS APPLICANT WORKED PER WEEK:

10. DATES OF EXPERIENCE: (MM/DD/YY)
(MUST REFLECT ONLY THE DATES **YOU** PROVIDED SUPERVISION)
FROM: / / TO: / /

*DOCTORATE OF AUDIOLOGY STUDENTS **ONLY**. THIS APPLICANT HAS COMPLETED THE 4TH YEAR (12-MONTH EXTERNSHIP) AS REQUIRED BY THE AUDIOLOGY DOCTORAL PROGRAM:
YES ____ NO ____

PRINT APPLICANTS FULL NAME _____ RPE NUMBER _____

11. WAS THE APPLICANT EMPLOYED AS A SALARIED EMPLOYEE OF A PUBLIC SCHOOL (COUNTY OFFICE OF EDUCATION)?

YES ____ NO ____

A. WHAT WAS THE SCHOOL SCHEDULE: TRADITIONAL _____ YEAR ROUND _____ SUMMER SCHOOL _____

YOU MUST ATTACH A SCHOOL CALENDAR THAT REFLECTS THE NAME OF SCHOOL OR DISTRICT AND ALL SCHOOL BREAKS AND HOLIDAYS.

WILL THE APPLICANT CONTINUE TO WORK UNDER YOUR SUPERVISION IN THE FALL?

YES ____ NO ____

12. SUPERVISION:

____ I PROVIDED EIGHT HOURS A MONTH OF DIRECT SUPERVISION. FOUR OF THE EIGHT HOURS WERE IN SCREENING, THERAPY, AND EVALUATION.

____ I PROVIDED FOUR HOURS A MONTH OF DIRECT SUPERVISION. TWO OF THE FOUR HOURS WERE IN SCREEN, THERAPY, AND EVALUATION.

13. PERFORMANCE OF RPE APPLICANT WAS:

SATISFACTORY ☐ UNSATISFACTORY ☐

COMMENTS:

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT I HAVE DISCUSSED THE FOREGOING WITH THE APPLICANT AND THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT, AND I DID NOT SUPERVISE MORE THAN TWO (2) OTHER APPLICANTS OBTAINING THEIR REQUIRED PROFESSIONAL EXPERIENCE (RPE) DURING THE SAME PERIOD OF TIME. I FURTHER CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL STATEMENTS MADE HEREIN ARE TRUE IN EVERY RESPECT, AND THAT MISSTATEMENTS OR OMISSIONS OF MATERIAL FACTS MAY BE CAUSE FOR DENIAL OF THIS VERIFICATION, OR FOR SUSPENSION OR REVOCATION OF MY LICENSE.

_____ DATE

_____ SUPERVISOR'S SIGNATURE (IN BLUE INK)

INFORMATION COLLECTION AND ACCESS

THE SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD'S EXECUTIVE OFFICER IS THE PERSON WHO IS RESPONSIBLE FOR INFORMATION MAINTENANCE. SECTION 2532 OF THE BUSINESS AND PROFESSIONS CODE IS THE AUTHORITY, WHICH AUTHORIZES THE MAINTENANCE OF THE INFORMATION. ALL INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY MANDATORY INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE. THE INFORMATION PROVIDED WILL BE USED TO DETERMINE QUALIFICATION FOR LICENSURE. EACH INDIVIDUAL HAS THE RIGHT TO REVIEW HIS OR HER FILE MAINTAINED BY THE AGENCY SUBJECT TO THE PROVISIONS OF THE CALIFORNIA PUBLIC RECORDS ACT.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (check one) ___ Employment X License, Certification, Permit ___ Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
Agency authorized to receive criminal history information

06187
Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100
Street No. Street or PO Box

N/A
Contact Name (Mandatory for all school submissions)

Sacramento CA 95815
City State Zip Code

( )
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ___ Male ___ Female

Misc. No. **BIL -** Applicant Must Pay At Site
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: 7700 SLP/AU
OCA No. (Agency Identifying No.)

Level of Service DOJ X FBI X

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (check one) ___ Employment X License, Certification, Permit ___ Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
Agency authorized to receive criminal history information

06187
Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100
Street No. Street or PO Box

N/A
Contact Name (Mandatory for all school submissions)

Sacramento CA 95815
City State Zip Code

( )
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ___ Male ___ Female

Misc. No. **BIL -** Applicant Must Pay At Site
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: 7700 SLP/AU
OCA No. (Agency Identifying No.)

Level of Service DOJ X FBI X

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (check one) ___ Employment X License, Certification, Permit ___ Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
Agency authorized to receive criminal history information

06187
Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100
Street No. Street or PO Box

N/A
Contact Name (Mandatory for all school submissions)

Sacramento CA 95815
City State Zip Code

( )
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. **BIL -** Applicant Must Pay At Site
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: 7700 SLP/AU
OCA No. (Agency Identifying No.)

Level of Service DOJ X FBI X

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

BCII 8016 (Rev10/98) **ORIGINAL-Live Scan Operator; SECOND COPY-Requesting Agency; THIRD COPY-Applicant**